

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2012
NAME OF PROVIDER OR SUPPLIER BRIDGE AT ROCKWOOD, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 ROANE STATE HWY ROCKWOOD, TN 37854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies This Rule is not met as evidenced by: During complaint investigation #29209 conducted June 6-25, 2012, at The Bridge at Rockwood, no deficiencies were cited under 1200-8-6 Standartds for Nursing Homes.	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1